

## 0.a. Goal

Goal 16: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels

## 0.b. Target

Target 16.6: Develop effective, accountable and transparent institutions at all levels

## 0.c. Indicator

Indicator 16.6.2: Proportion of population satisfied with their last experience of public services

## 0.e. Metadata update

19 April 2021

## 0.f. Related indicators

SDG indicator 16.6.2, measured from citizen surveys, is an important complement to other SDG indicators assessing various aspects of public service provision that draw from administrative sources, such as SDG 3.8.1 on coverage of essential health services<sup>[1]</sup> and SDG 4.a.1 on school facilities<sup>[2]</sup>. While these indicators focus on similar attributes as those measured by SDG 16.6.2, such as ‘accessibility’ and ‘quality of facilities’, they may not reflect people’s actual experience of education facilities or healthcare services due to the methodological challenges of collecting quality data from administrative sources.

Amongst SDG indicators assessing various aspects of public service provision, indicator 1.4.1, which measures the “proportion of population living in households with access to basic services” has particular relevance to indicator 16.6.2:

- Indicator 1.4.1 measures ‘Access to Basic Health Care Services’ by drawing on readily available data reported on SDG indicator 3.7.1 on access to reproductive health (Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods). Indicator 16.6.2 therefore provides important additional information by (1) broadening the scope of measurement from reproductive health to ‘basic healthcare services’ as internationally defined, and (2) by assessing five key attributes of healthcare service provision not assessed by 1.4.1, namely access, affordability, quality of facilities, equal treatment for everyone and doctor’s attitude, and (3) by using survey data to measure people’s satisfaction with healthcare services based on their last experience.
- Indicator 1.4.1 also measures ‘Access to Basic Education’ by drawing on readily available data reported on SDG indicator 4.1.1 on educational achievements (Percentage of children/young people: (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics). Indicator 16.6.2 therefore provides important additional information by (1) assessing four key attributes of education service provision not assessed by 1.4.1, namely access, affordability, quality of facilities and equal treatment for everyone, and (2) by using survey data (SDG 4.1.1 uses test scores) to measure people’s satisfaction with education services based on their first-hand experience with such services.

Indicator 16.6.2 can also be used to complement SDG target 10.2 on the promotion of the “social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status”, which only has one indicator measuring economic exclusion (SDG 10.2.1 – Proportion of people living below 50 per cent of median income, by age, sex and persons with disabilities). Indicator 16.6.2 therefore provides important additional information to measure progress against this target by providing data on social inclusion.

Similarly, 16.6.2 can also be used to complement SDG target 10.3 on “Ensuring equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard”, which only has one indicator measuring felt discrimination on various grounds (SDG 10.3.1 Proportion of the population reporting having personally felt discriminated against or harassed within the previous 12 months on the basis of a ground of discrimination prohibited under international human rights law). Indicator 16.6.2 therefore provides important additional information to measure progress against this target by helping to identify in which service area the incidence of discrimination is highest.

Finally, SDG 16.6.2, with its focus on ‘accessibility’, ‘equal treatment’ and other important attributes of public services, provides important complementary information to analyze results on SDG 16.5.1 on the ‘Proportion of persons who had at least one contact with a public official and who paid a bribe to a public official, or were asked for a bribe by those public officials, during the previous 12 months’. In other words, people may resort to bribery when the quality of public service provision is too poor, as revealed by SDG 16.6.2.

- 1 3.8.1 Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population) [↑](#)
- 2 4.A.1 Proportion of schools with access to: (a) electricity; (b) the Internet for pedagogical purposes; (c) computers for pedagogical purposes; (d) adapted infrastructure and materials for students with disabilities; (e) basic drinking water; (f) single-sex basic sanitation facilities; and (g) basic handwashing facilities (as per the WASH indicator definitions) [↑](#)

## 0.g. International organisations(s) responsible for global monitoring

UNDP Oslo Governance Centre

### 1.a. Organisation

UNDP Oslo Governance Centre

### 2.a. Definition and concepts

#### Definition:

This indicator measures levels of public satisfaction with people's last experience with public services, in the three service areas of healthcare, education and government services (i.e. services to obtain government-issued identification documents and services for the civil registration of life events such as births, marriages and deaths)<sup>[3]</sup>. This is a survey-based indicator which emphasizes citizens' *experiences* over general perceptions, with an eye on measuring the availability and quality of services *as they were actually delivered to survey respondents*.

Respondents are asked to reflect on their last experience with each service, and to provide a rating on five 'attributes', or service-specific standards, of healthcare, education and government services (such as access, affordability, quality of facilities, etc.). A final question asks respondents for their overall satisfaction level with each service.

It is recommended that survey results, at a minimum, be disaggregated by sex, income and place of residence (urban/rural, administrative regions). To the extent possible, all efforts should be made to also disaggregate results by disability status and by 'nationally relevant population groups'.

#### Concepts:

- **Public services:** As stated by the United Nations High Commissioner for Human Rights, "States are responsible for delivering a variety of services to their populations, including education, health and social welfare services. The provision of these services is essential to the protection of human rights such as the right to housing, health, education and food. The role of the public sector as service provider or regulator of the private provision of services is crucial for the realization of all human rights, particularly social and economic rights."<sup>[4]</sup>

While several definitions of 'public services' exist, they tend to have in common a focus on 'common interest' and on 'government responsibility'. For instance, the European Commission defines such services as "Services that public authorities of the Member States clarify as being of general interest and, therefore, subject to specific public service obligations."<sup>[5]</sup> Similarly, the African Charter on Values and Principles of Public Service and Administration (African Union, 2011) defines a public service as "Any service or public-interest activity that is under the authority of the government administration".

- **Public services 'of general interest':** The methodology for SDG 16.6.2 carefully defines the scope of healthcare and education services to ensure that the focus is placed on services that are truly *of general interest*. In the case of healthcare services, for instance, preventive and primary healthcare services can be said to be truly 'of general interest': these services are relevant to everyone and they are most commonly found in both urban and rural areas. This might not be the case for hospitals that provide tertiary care, and as such hospital and specialist care is excluded from the questions on healthcare services. Likewise, in the case of education services, primary and lower secondary education services can be said to be truly 'of general interest', given their universality. University education, however, is excluded from the questions on education services.
- **'Last experience' of public services in the past 12 months:** Indicator 16.6.2 focuses on respondents' 'last experience of public services', and specifies a reference period of "the past 12 months" to avoid telescoping effects and to minimize memory bias effects. This means that only respondents who will have used healthcare, education and government services in the past 12 months will proceed to answer the survey questions.
- **Service-specific standards – or 'attributes':** The United Nations High Commissioner for Human Rights explains that "A human rights-based approach to public services is integral to the design, delivery, implementation and monitoring of all public service provision. Firstly, the normative human rights framework provides an important legal yardstick for measuring how well public service is designed and delivered and whether the benefits reach rights-holders"<sup>[6]</sup>. For instance, the Committee on Economic, Social and Cultural Rights specifies that "The availability, accessibility, acceptability and quality of health-related services should be facilitated and controlled by States. This duty extends to a variety of health-related services

ranging from controlling the spread of infectious diseases to ensuring maternal health and adequate facilities for children.”<sup>[7]</sup> Similarly, with respect to education services, the same Committee underlines that “States should adopt a human rights approach to ensure that [education services are] of an adequate standard and do not exclude any child on the basis of race, religion, geographical location or any other defining characteristic.”<sup>[8]</sup>

- **Healthcare services:** The questions on healthcare services focus on respondents’ experiences (or that of a child in their household who needed treatment and was accompanied by the respondent) with *primary* healthcare services (over the past 12 months) – that is, basic health care services provided by a government/public health clinic, or covered by a public health system. It can include health care services provided by private institutions, as long as such services are provided at reduced (or no) cost to beneficiaries, under a public health system. Respondents are specifically asked *not* to include in their answers any experience they might have had with hospital or specialist medical care services (for example, if they had a surgery), or with dental care and teeth exams (because in many countries, dental care is not covered by publicly funded healthcare systems). Attributes-based questions on healthcare services focus on 1) Accessibility (related to geographic proximity, delay in getting appointment, waiting time to see doctor on day of appointment); 2) Affordability; 3) Quality of facilities; 4) Equal treatment for everyone; and 5) Courtesy and treatment (attitude of healthcare staff).
- **Education services:** The questions on education services focuses on respondents’ experience with the *public school system* over the past 12 months, that is, if there are children in their household whose age falls within the age range spanning primary and secondary education in the country. Public schools are defined as “those for which no private tuition fees or major payments must be paid by the parent or guardian of the child who is attending the school; they are state-funded schools.” Respondents are asked to respond separately for primary and secondary schools if children in their household attend school at different levels. Attributes-based questions on education services focus on 1) Accessibility (with a focus on geographic proximity); 2) Affordability; 3) Quality of facilities; 4) Equal treatment for everyone; and 5) Effective delivery of service (Quality of teaching).
- **Government services:** The battery on government services focuses exclusively on two types of government services: 1) Services to obtain government-issued identification documents (such as national identity cards, passports, driver’s licenses and voter’s cards) and 2) services for the civil registration of life events such as births, marriages and deaths. This particular focus on these two types of services arises from the high frequency of use of these services. Attributes-based questions on government services focus on 1) Accessibility; 2) Affordability; 3) Equal treatment for everyone; 4) Effective delivery of service (delivery process is simple and easy to understand); and 5) Timeliness.

### Selection of relevant disaggregation dimensions

- *Relevant international legal frameworks:* Indicator 16.6.2 aims to provide a better understanding of how access to services and the quality of services differ across localities and across various demographic groups. This aim is supported by international human rights law:
- Article 25 (c) of the International Covenant on Civil and Political Rights provides for the right to *equal access* to public service. In its report on the role of the public services as an essential component in the promotion and protection of human rights, the United Nations High Commissioner for Human Rights reminds that “States must bear in mind that there are demographic groups in every society that may be disadvantaged in their access to public services, namely women, children, migrants, persons with disabilities, indigenous persons and older persons. States need to ensure that the human rights of these groups are not undermined and that they receive adequate public services.”<sup>[9]</sup> The High Commissioner also calls attention to the fact that “Poverty acts as a major barrier in relation to public services.”
- The obligations to ensure equality and non-discrimination are recognized in article 2 of the Universal Declaration of Human Rights and are encountered in many United Nations human rights instruments, such as the International Covenant on Civil and Political Rights (arts. 2 and 26), the International Covenant on Economic, Social and Cultural Rights (art. 2 (2)), the Convention on the Rights of the Child (art. 2), the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (art. 7) and the Convention on the Rights of Persons with Disabilities (art. 5). In terms of public services, this means that States have an immediate obligation to ensure that deliberate, targeted measures are put into place to secure substantive equality and that all individuals have an equal opportunity to enjoy their right to access public services.
- *Empirical analysis:* Statistical analysis of available datasets on citizen satisfaction with healthcare and education services<sup>[10]</sup> shows that the demographic variables that are most strongly correlated with satisfaction with healthcare and education services are (1) income (by far the strongest determinant of satisfaction levels), (2) sex, and (3) place of residence (rural/urban). There is no statistically significant association between the age of respondents and satisfaction levels.

<sup>3</sup> The formulation ‘government services’ (also commonly called ‘administrative services’) is used in this metadata to mirror this more colloquial language used in the survey questionnaire. [↑](#)

<sup>4</sup> *Good Governance Practices for the Protection of Human Rights* (United Nations publication, Sales No. E.07.XIV.10), p. 38 – cited in Report of the United Nations High Commissioner for Human Rights on the role of the public service as an essential component of good governance in the promotion and protection of human rights, Human Rights Council, 25<sup>th</sup> Session, 23 December 2013, A/HRC/25/27 [↑](#)

<sup>5</sup> European Commission’s 2011 Communication regarding ‘A Quality Framework for Services of General Interest in Europe’, p. 3 [↑](#)

<sup>6</sup> Report of the United Nations High Commissioner for Human Rights on the role of the public service as an essential component of good governance in the promotion and protection of human rights, Human Rights Council, 25<sup>th</sup> Session, 23 December 2013, A/HRC/25/27 [↑](#)

<sup>7</sup> Committee on Economic, Social and Cultural Rights, General Comment No. 14 (2000) on the right to the highest attainable standard of health, para. 4. [↑](#)

<sup>8</sup> Committee on Economic, Social and Cultural Rights, general comment No. 13 (1999) on the right to education, para. 1. [↑](#)

<sup>9</sup> Report of the United Nations High Commissioner for Human Rights on the role of the public service as an essential component of good governance in the promotion and protection of human rights, Human Rights Council, 25<sup>th</sup> Session, 23 December 2013, A/HRC/25/27 [↑](#)

<sup>10</sup> From the European Social Survey, the European Quality of Life Survey and the Afrobarometer – see more information in the section on “Data Availability”. [↑](#)

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## 2.b. Unit of measure

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Percentage

## 2.c. Classifications

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Not applicable

## 3.a. Data sources

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- This indicator needs to be measured on the basis of data collected by NSOs through official household surveys.

## 3.b. Data collection method

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NSOs should identify suitable survey vehicles to incorporate the 16.6.2 batteries of question. Some countries may not have an integrated or unified survey covering various public services. In countries where each Ministry/Department/Agency conducts its respective satisfaction survey, the NSO should liaise with each entity to harmonize existing survey questions with this metadata.

## 3.c. Data collection calendar

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To ensure timely capture of changes in levels of citizen satisfaction with public services, NSOs should report data on indicator 16.6.2 at least once every two years.

NSOs will need to choose the most appropriate time/period for administering the 16.6.2 batteries of questions. Electoral periods should be avoided, and NSOs should aim for the middle of an electoral term. Experience shows that surveys conducted at the beginning of an electoral term generate more positive responses than surveys conducted at the end of a term.

## 3.d. Data release calendar

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Data will be reported at the international level in April each year. The first full release of data for the indicator will take place in April 2020.

## 3.e. Data providers

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National Statistical Offices

## 3.f. Data compilers

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UNDP

## 3.g. Institutional mandate

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Recent evidence shows that citizens call for responsive and inclusive public institutions with capacity to efficiently deliver services. To advance these aspirations from societies, UNDP helps countries to strengthen responsive and accountable institutions. UNDP recognizes the foundational importance of effective and responsive governance to achieve sustainable development.

## 4.a. Rationale

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Governments have an obligation to provide a wide range of public services that should meet the expectations of their citizens in terms of access, responsiveness and reliability/quality. When citizens cannot afford some essential services, when their geographic or electronic access to services and information is difficult, when the services provided do not respond to their needs and are of poor quality, citizens will naturally tend to report lower satisfaction not only with these services, but also with public institutions and governments. In this regard, it has been shown that citizens' experience with front-line public services affects their trust in public institutions (OECD 2017, *Trust and Public Policy – How Better Governance Can Help Rebuild Public Trust*; Eurofound 2018, *Societal change and trust in institutions*). Mindful of this close connection between service provision/performance, citizen satisfaction and public trust, governments are increasingly interested in better understanding citizens' needs, experiences and preferences to be able to provide better targeted services, including for underserved populations.

Measuring satisfaction with public services is at the heart of a citizen-centered approach to service delivery and an important outcome indicator of overall government performance. Yet while a large number of countries have experience with measuring citizen satisfaction with public services, there is also large variability in the ways national statistical offices and government agencies in individual countries collect data in this area, in terms of the range of services included, the specific attributes of services examined, question wording and response formats, among other methodological considerations. This variability poses a significant challenge for cross-country comparison of such data.

SDG indicator 16.6.2 aims to generate globally comparable data on satisfaction with public services. To this end, SDG 16.6.2 focuses global reporting on the three service areas of (1) healthcare, (2) education and (3) government services (i.e. services to obtain government-issued identification documents and services for the civil registration of life events such as births, marriages and deaths.)

The rationale for selecting these three public services is threefold:

- First, these are 'services of consequence'<sup>[11]</sup>, salient for all countries and for both rural and urban populations within countries. They are also among the most common service areas covered by national household or citizen surveys on satisfaction with public services<sup>[12]</sup>.
- Second, while healthcare and education services are covered by other SDG indicators<sup>[13]</sup>, most of these other indicators rely on administrative sources (i.e. they do not measure people's direct experiences and level of satisfaction with services) and are mainly focused on measuring the national coverage of a given service.
- Third, government services are not monitored under other Goals. This is a gap that indicator 16.6.2 can usefully fill, especially since Goal 16 is dedicated to enhancing governance. While Goal 16 does consider birth registration services under indicator 16.9.1, it falls short of measuring satisfaction with the services provided.

With the aim of generating harmonized statistics, indicator 16.6.2 is measured through five attributes-based questions under each service area (e.g. on the accessibility and affordability of the service, the quality of facilities, etc.):

- The attributes-based questions are asked *before* the overall satisfaction question. This is based on the intention to enhance the accuracy of the proposed statistical measure on overall satisfaction – that is, to ensure that it correctly reflects the underlying concept that it is intended to capture (based on the specific attributes selected for each service). Experts in governance measurements have found that citizen satisfaction with public services is influenced not only by citizens' previous experiences with the services, but also by citizens' expectations<sup>[14]</sup>. These can be influenced by cultural assumptions about the extent to which service providers should be responsive to citizens' preferences; by broad public perception of services as communicated through the media; by individual experiences of friends, family and acquaintances; and by how service providers themselves communicate about the type of services they commit to delivering. For instance, national experiences with different question formats have shown that more highly educated respondents who interact more frequently with government (and who possibly have higher awareness of their own rights and of their government's obligations) have higher expectations in terms of what constitutes a public service of 'good quality', compared to the rest of the population<sup>[15]</sup>.
- Given these multiple influences over citizen expectations of public services, which differ across different national contexts and across different demographic groups, it is essential for this methodology to foster a common understanding among respondents of which aspects of 'good quality' service provision are measured. To this end, this methodology 'primes' respondents with a common set of attributes of 'good quality' service provision prior to asking about their overall satisfaction.
- National experiences have also shown that asking attributes-based questions prior to an overall satisfaction question helps respondents recall their last experience with more specificity.<sup>[16]</sup>
- A key reference used to identify relevant attributes for each service area covered by SDG 16.6.2 is the OECD Serving Citizens Framework (OECD 2015, *Government at a Glance*), which measures the quality of public services delivered to citizens by assessing three key dimensions of service provision, namely Access<sup>[17]</sup>, Responsiveness<sup>[18]</sup> and Reliability/Quality<sup>[19]</sup>. Each one of these three dimensions is then further assessed with specific attributes.
- The list of attributes in the OECD Serving Citizens Framework is comprehensive and more than a global indicator can feasibly and usefully cover. SDG 16.6.2, therefore, focuses on a limited subset of attributes. The specific set of five attributes used by SDG 16.6.2 to measure satisfaction with healthcare and education service areas was selected on the basis of statistical analysis performed on accessible datasets on satisfaction with these two services, namely from the Afrobarometer and the European Quality of Life Survey. Regression and cluster analysis were conducted on these two datasets to determine the main 'drivers' of overall satisfaction among several such attributes, for healthcare and education services<sup>[20]</sup>. The below table presents the results of this empirical analysis – that is, the subset of five attributes used by SDG 16.6.2 to assess satisfaction in each service area:

**Attributes of public services found to be the biggest 'drivers' of satisfaction with healthcare and education services (in Europe and Africa)**

Attributes	Healthcare service	Education service
1	Accessibility ( <i>includes a range of issues such as geographic proximity, delay in getting appointment, waiting time to see doctor on day of appointment</i> )	Accessibility ( <i>geographic proximity</i> )
2	Affordability	Affordability
3	Quality of facilities	Quality of facilities
4	Equal treatment for everyone	Equal treatment for everyone
5	Courtesy and treatment ( <i>Attitude of healthcare staff</i> )	Effective delivery of service ( <i>Quality of teaching</i> )

**Source:** Statistical analysis by the UNDP Oslo Governance Centre, 2019

- Attributes-specific questions aim to be specifically informative for national policymaking. The specificity of the information generated by such questions, as well as the focus on citizen *experiences* rather than simply perceptions, have greater policy use than stand-alone perception data on overall satisfaction, which may not reveal “what needs to be fixed”.

<sup>11</sup> While drinking water and sanitation services are also ‘services of consequence’, they are already well covered by SDG indicator 6.1.1 “Proportion of population using safely managed drinking water services” and SDG indicator 6.2.1 “Proportion of population using safely managed sanitation services, including a hand-washing facility with soap and water” which also draw from citizen surveys (Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP) supported by UNICEF and WHO) and look at access, availability and quality. [↑](#)

<sup>12</sup> See UNDP Oslo Governance Centre (Nov 2017), A Review of National Statistics Offices’ Practices and Methodological Considerations in Measuring Citizen Satisfaction with Public Services – Inputs for SDG Indicator 16.6.2 Measurement Methodology [↑](#)

<sup>13</sup> For health care services, 3.8.1, 3.5.1, 3.b.1 and 1.4.1, and for education services, 4.a.1 and 4.c.1. [↑](#)

<sup>14</sup> See Ellen Lust et al., 2015; Nick Thijs, 2011, Van Ryzin, 2004, for instance. [↑](#)

<sup>15</sup> Evidence from Mexico, National Survey of Quality and Governmental Impact (ENCIG) 2017 [↑](#)

<sup>16</sup> Ibid. [↑](#)

<sup>17</sup> Under the ‘Access’ dimension, three attributes are considered: ‘Affordability’, ‘Geographic proximity’ and ‘Accessibility of information’. [↑](#)

<sup>18</sup> Under the ‘Responsiveness’ dimension, three attributes are considered: ‘Citizen-centred approach (courtesy, treatment and integrated services)’, ‘Match of services to special needs’ and ‘Timeliness’. [↑](#)

<sup>19</sup> Under the ‘Reliability/Quality’ dimension, three attributes are considered: ‘Effective delivery of services and outcomes’, ‘Consistency in service delivery and outcomes’ and ‘Security/safety’. [↑](#)

<sup>20</sup> In the absence of regional or global datasets on satisfaction with government services, the same empirical analysis could not be performed in this service area. To the extent possible, similar attributes are used to assess satisfaction with government services as those used for healthcare and education services, with a distinct focus on the attribute of ‘timeliness’ in the case of government services. [↑](#)

## 4.b. Comment and limitations

### Recommended set of complementary questions to address selection 16.6.2 bias towards ‘users’ of public services

- Since SDG 16.6.2 refers to people’s ‘last experience’ with public services, the indicator needs to focus on user experiences rather than on non-user perceptions. The experience of users is important, but it is equally important to understand the experiences and perceptions of those who turn elsewhere for services, or who do not access services altogether.



- For each service area, NSOs are therefore strongly encouraged to administer three complementary questions (see Methodology section) *prior* to the two ‘priority questions’ to be used for global 16.6.2 reporting. These additional questions will help capture the experience of *both* users *and* non-users of public services. They will help identify which population sub-groups who needed healthcare, education and government services did *not* access the services they needed, and what barriers prevented them from doing so. While the information generated by these additional questions is critical for policymakers to design service provision programmes that ‘leave no one behind’, it is left to the discretion of each country to integrate them or not, as some may already be collecting similar information through existing surveys.

Otherwise, the selection bias inherent in SDG 16.6.2, with its focus on users, can result in mismeasurement due to underlying inequalities in the propensity of various groups to interact with state institutions. In other words, a focus on ‘the last experience with public services’ implicitly means that this indicator includes only those respondents who were privileged enough to access public services in the past year. This means that those (such as ethnic minorities, migrants, the elderly, undocumented workers) who have *not* been able – or willing – to access the healthcare, education or government services they needed in the past 12 months, often as a consequence of multiple social and economic barriers arising from overlapping forms of marginalization will be undercounted by this indicator. There is a risk therefore that overall satisfaction levels reported on 16.6.2 will over-represent the experience of more privileged groups for whom access to public services is easier, because they have the financial, logistical and intellectual means to do so, and they trust that it is in their interest to do so.

#### Answer scales:

- To ensure the consistency of measurement in an international context, a standardised approach to response format is required. Available evidence from piloting and other NSO experiences suggests that a four-point Likert-scale with verbal scale anchors is preferable over the alternatives. A four-point scale offers the optimal range of response options for the concepts at hand, in terms of capturing as much meaningful variation between responses as there exists, while remaining understandable for respondents who are not very numerate or literate. Piloting experiences have revealed that offering too few response options (such as a ‘yes/no’ binary response format) would not reveal much variation and might even frustrate some respondents, who might feel their satisfaction level cannot be accurately expressed. Furthermore, the Guidelines on Measuring Subjective Well-Being (OECD, 2013) caution against using “agree/disagree, true/false, and yes/no response formats in the measurement of subjective well-being due to the heightened risk of acquiescence and socially desirable responding”. Meanwhile, piloting experiences have shown that respondents would be equally burdened by too many response categories (such a 7- or 10-point scale), especially if the categories are too close to distinguish between them cognitively.
- There are different schools of thought on whether an odd or even number of categories is best when using Likert scales. While taking away the middle category forces respondents to voice a positive or negative opinion, and some respondents might find this approach frustrating, several NSOs in developing country contexts favor a Likert scale *without* a neutral value (such as “neither satisfied nor dissatisfied”). Their preference is motivated by their long-standing survey experience which has shown that when a neutral value is provided, a large proportion (often a majority) of respondents will refrain from expressing their opinion ‘hiding’ behind this middle-point.
- The survey methodology for 16.6.2 therefore uses a 4-point bipolar Likert scale for all questions (for internal consistency), with the following scale labels: “strongly agree, agree, disagree, strongly disagree” for attributes-based questions, and “very satisfied, satisfied, dissatisfied, very dissatisfied” for overall satisfaction questions. “Don’t know” and “refuse to answer” options are also available, but *should not be read out loud*, so as to not provide an easy way for respondents to disengage from the subjects of the various questions. When respondents say they “don’t know”, enumerators should repeat the question and simply ask them to provide their best guess. The “don’t know” and “refuse to answer” options should be used only as a last resort.

## 4.c. Method of computation

Reporting on SDG 16.6.2 should be done separately for each of the three service areas. (NB: questions on education may refer to either primary or secondary education – and separate computation of results is recommended for the two levels, resulting in *de facto* four service areas). Computation involves the computation and reporting of the following three estimates, for each service area:

- The share of respondents who responded positively (i.e. ‘strongly agree’ or ‘agree’) to each of the five attributes questions;
- The simple average of positive responses for the five attribute questions combined; and
- The share of respondents who say they are satisfied (i.e. those who responded ‘very satisfied’ or ‘satisfied’) in the overall satisfaction question.

For instance:

Attributes of healthcare services	Positive responses	Attributes of primary education services	Positive responses	Attributes of secondary education services	Positive responses	Attributes of government services	Positive responses
Accessibility	50% respondents 'strongly agree' or	Accessibility		Accessibility		Accessibility	

	'agree'						
Affordability	60% respondents 'strongly agree' or 'agree'	Affordability		Affordability		Affordability	
Quality of facilities	73% respondents 'strongly agree' or 'agree'	Quality of facilities		Quality of facilities		Effective service delivery process	
Equal treatment for everyone	55% respondents 'strongly agree' or 'agree'	Equal treatment for everyone		Equal treatment for everyone		Equal treatment for everyone	
Courtesy and treatment (Attitude of healthcare staff)	42% respondents 'strongly agree' or 'agree'	Effective delivery of service (Quality of teaching)		Effective delivery of service (Quality of teaching)		Timeliness	
Average share of positive responses on attributes of healthcare services	$(50+60+73+55+42)/5 = 56\%$	Average share of positive responses on attributes of primary education services		Average share of positive responses on attributes of secondary education services		Average share of positive responses on attributes of government services	
Share of respondents satisfied with healthcare services overall	(23% 'very satisfied' + 37% 'satisfied') = 60%	Share of respondents satisfied with primary education services overall		Share of respondents satisfied with secondary education services overall		Share of respondents satisfied with government services overall	

*\*Note: It is important for NSOs to clearly report, for each question, the number of respondents who selected “don’t know” (DK), “not applicable” (NA) or “refuse to answer” (RA), and to exclude such respondents from the calculation of shares of positive responses. For instance, if 65 respondents out of 1000 respondents responded DK, NA or RA on the first attribute-based question, the share of positive responses for this attribute will be calculated out of a total of 935 respondents, and the reporting sheet will indicate that for this particular question, 65 respondents responded DK/NA/RA.*

While national-level reporting should cover all three estimates described above, global reporting on SDG indicator 16.6.2 will focus only on the last two estimates (i.e. the average share of positive responses across the five attribute questions; and the share of respondents who say they are satisfied in the overall satisfaction question), separately for each service area.

#### 4.d. Validation

The countries are requested to input the indicators' data and metadata in a reporting platform following the guidelines in the present metadata sheet. The platform encourages to provide separate information on the survey metadata, namely the source of information for the statistics, the survey instruments, the methodology and protocols and possible. Countries are also requested to insert the statistics on the two questions disaggregated by the pre-specified fields. All inputted information is verified for conformity with the metadata prior to submission.

#### 4.e. Adjustments



Not applicable.

## 4.f. Treatment of missing values (i) at country level and (ii) at regional level

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- At country level

There is no treatment of missing values.

- At regional and global levels

There is no imputation of missing values.

## 4.g. Regional aggregations

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Data points will be provided for each region, and globally (i.e. two data points for each service area: combined average % of those who responded positively to the five attributes questions, and % satisfied with the service overall).

## 4.h. Methods and guidance available to countries for the compilation of the data at the national level

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### Methods and guidance available to countries for the compilation of data at national level:

See [Indicators of Citizen-Centric Public Service Delivery](#), World Bank (2018)

To disaggregate survey results by disability status, it is recommended that countries use the [Short Set of Questions on Disability elaborated by the Washington Group](#).

### Methods and guidance available to countries for the compilation of data at international level:

See [Indicators of Citizen-Centric Public Service Delivery](#), World Bank (2018)

To disaggregate survey results by disability status, it is recommended that countries use the [Short Set of Questions on Disability elaborated by the Washington Group](#).

## 4.i. Quality management

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Statistics for this indicator is inputted in the reporting platform (<https://sdg16reporting.undp.org/login>). UNDP has dedicated staff to verify the collected data and liaise with the data officers in the agency in the countries.

## 4.j. Quality assurance

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NSOs have the main responsibility to ensure the statistical quality of the data compiled for this indicator. One possible quality assurance mechanism would be to compare results obtained by the NSO with readily available survey results on satisfaction with public services generated by relevant national, regional or global non-official data producers (see potential non-official sources below).

## 4.k. Quality assessment

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UNDP will make available a quality assessment protocol for national statistics office to be used at national level and intended to assess the alignment of data produced with users needs, the compliance with guidelines in terms of computations, the timeliness of data production, the accessibility of statistics produced, the consistent use of methodology both in terms of geographic representation and through time, the coherence in terms of data production, and the architecture of data production.

## 5. Data availability and disaggregation

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Data availability:

- This indicator needs to be measured on the basis of data collected by NSOs through official household surveys.

Description and time series:

- There is no existing globally comparable official dataset on the “Proportion of the population satisfied with their last experience of public services.” While a large number of countries have experience with measuring citizen satisfaction with public services, there is large variability in the ways NSOs and government agencies in individual countries collect data on citizen satisfaction with public services, in terms of the range of services included, the specific attributes examined, question wording and response formats, etc. This variability poses a significant challenge for cross-country comparability of such data.
- A number of global and regional sources provide comparable data on some measures of citizen satisfaction with public services. For instance, the [Gallup World Poll](#) (not publicly available, but data collected for more than 150 countries) asks people how satisfied they are with education and healthcare public services in their local area. However, the Gallup World Poll questions do not ask specifically about satisfaction *with the last experience of public services*, and does not refer to specific attributes of public services to be considered by respondents when providing their assessment.
- At regional level, the Afrobarometer<sup>[21]</sup> has collected data on citizens’ satisfaction with healthcare and education services across Africa over seven survey rounds (from 1999/2001 to 2016/18), using the question “*How well or badly would you say the current government is handling the following matters, or haven’t you heard enough to say: Addressing educational needs? Improving basic health services?*” with the following answer categories: 1=Very badly, 2=Fairly badly, 3=Fairly well, 4=Very well.<sup>[22]</sup>
- Also at the regional (European) level, eight waves of the biennial European Social Survey<sup>[23]</sup> (from 2002 to 2016) provide time series data on perception of education and health services in Europe. The relevant survey questions are: *What do you think overall about the state of health (education) services in [country] nowadays?*, using a scale of 0 (extremely bad) to 10 (extremely good). Once again, these survey questions do not ask specifically about satisfaction *with the last experience of public services*, and do ask respondents to consider specific attributes of public services when providing their assessment.
- The fourth edition of the European Quality of Life Survey<sup>[24]</sup> (EQLS) in 2016 had a specific focus on the quality of public services, with questions on *both* overall satisfaction levels with healthcare and education services, *and* satisfaction with specific attributes of service provision, several of which match the attributes selected for global reporting on 16.6.2. This focus on the quality of public service provision is expected to remain in future iterations of the EQLS survey, and this survey could therefore become an appropriate source of data for reporting on SDG 16.6.2 for 33 participating countries – namely the 28 EU Member States and 5 candidate countries (Albania, the former Yugoslav Republic of Macedonia, Montenegro, Serbia and Turkey). More specifically, the following corresponding questions in the EQLS have been identified, jointly with Eurofound experts, to report on SDG 16.6.2:

Healthcare services <sup>[25]</sup>		
Attributes	SDG 16.6.2 questions	Corresponding EQLS questions
Access	Q 4.1 It was easy to get to the place where I received medical treatment. (0-3)	Q61 - Thinking about the last time you needed to see or be treated by a GP, family doctor or health centre, to what extent did any of the following make it difficult or not for you to do so? [Very difficult (1); a little difficult (2); not difficult at all (3)]:  a. Distance to GP/doctor’s office / health centre  b. Delay in getting appointment  c. Waiting time to see doctor on day of appointment
Affordability	Q 4.2 Expenses for healthcare services were affordable to you/your household. (0-3)	Q61 – Same as above:  d. Cost of seeing the doctor
Quality of facilities	Q 4.3 The healthcare facilities were clean and in good condition. (0-3)	Q62 - You mentioned that you used GP, family doctor or health centre services. On a scale of 1 to 10 where 1 means very dissatisfied and 10 means very satisfied, tell me how satisfied or dissatisfied you were with each of the following aspects the last time that you used the service.  1. Quality of the facilities (building, room, equipment)
Equal	Q 4.4 All people are treated equally in receiving	Q63 - To what extent do you agree or disagree with

<b>treatment for everyone</b>	<i>healthcare services in your area. (0-3)</i>	the following about GP, family doctor or health centre services in your area? [on a scale of 1 to 10, where 1 means completely disagree and 10 means completely agree]:  a. All people are treated equally in these services in my area
<b>Courtesy and treatment (Doctor's attitude)</b>	<i>The doctor or other healthcare staff you saw spent enough time with you [or a child in your household] during the consultation. (0-3)</i>	Q62 - Satisfaction with the following aspects [on a scale of 1 to 10 where 1 means very dissatisfied and 10 means very satisfied]:  c. Personal attention you were given, including staff attitude and time devoted
<b>Overall satisfaction</b>	<i>Overall, how satisfied or dissatisfied were you with the quality of the healthcare services you [or a child in your household] received on that last consultation? (i.e. the last time you [or a child in your household] had a medical examination or treatment in the past 12 months)</i>  <i>Very dissatisfied (0) - Dissatisfied (1) – Satisfied (2) – Very satisfied (3)</i>	Q58 - In general, how would you rate the quality of each of the following public services in [COUNTRY]? [on a scale of one to 10, where 1 means very poor quality and 10 means very high quality]  a. Health services
<b>Education services</b>		
<b>Attributes</b>	<b>SDG 16.6.2 questions</b>	<b>Corresponding EQLS questions</b>
<b>Access</b>	<i>Q. 9.1 The school can be reached by public or private transportation, or by walk, in less than 30 minutes and without difficulties. (0-3)</i>	<u>No relevant EQLS question</u>
<b>Affordability</b>	<i>Q. 9.2 School-related expenses (including administrative fees, books, uniforms and transportation) are affordable to you/your household. (0-3)</i>	<u>No relevant EQLS question</u> <a href="#">[26]</a>
<b>Quality of facilities</b>	<i>Q. 9.3 School facilities are in good condition. (0-3)</i>	Q85 - You mentioned that your child or someone in your household attended school. On a scale of 1 to 10 where 1 means very dissatisfied and 10 means very satisfied, please tell me how satisfied or dissatisfied you were with each of the following aspects.  a. Quality of the facilities (building, room, equipment)
<b>Equal treatment for everyone</b>	<i>Q. 9.4 All children are treated equally in the school attended by the child/children in your household. (0-3)</i>	Q86 - To what extent do you agree or disagree with the following statements about school services in your area? Please tell me on a scale of 1 to 10, where 1 means completely disagree and 10 means completely agree.  a. All people are treated equally in these services in my area

<b>Effective delivery of service (Quality of teaching)</b>	Q. 9.5 <i>The quality of teaching is good. (0-3)</i>	Q85 - You mentioned that your child or someone in your household attended school. On a scale of 1 to 10 where 1 means very dissatisfied and 10 means very satisfied, please tell me how satisfied or dissatisfied you were with each of the following aspects.  b. Expertise and professionalism of staff/teachers  e. The curriculum and activities
<b>Overall satisfaction</b>	Q 10. <i>Overall, how satisfied or dissatisfied are you with the quality of education services provided by the primary and/or secondary public schools attended by this child/children in your household?</i>  <i>Are you reporting on:</i>  1. <i>Primary school in your area</i> ____ 2. <i>Secondary school in your area</i> ____  <i>Very dissatisfied (0) - Dissatisfied (1) – Satisfied (2) – Very satisfied (3)</i>	Q58 - In general, how would you rate the quality of each of the following public services in [COUNTRY]? [on a scale of one to 10, where one means very poor quality and 10 means very high quality]  b. Education system

### Disaggregation categories

Indicator 16.6.2 aims to measure how access to services and how the quality of services differs across various demographic groups. Empirical analysis to identify the strongest demographic determinants of citizen satisfaction with public services reveals that the most relevant disaggregation categories for SDG indicator 16.6.2 are (1) income, (2) sex and (3) place of residence (urban/rural, and by administrative region e.g. by province, state, district, etc.)

At a minimum, results *for each one of the three service areas* covered by this indicator (healthcare, education and government services) should be disaggregated by these three variables:

- **Income:** Income (or expenditure) quintiles
- **Sex:** Male/Female
- **Place of residence:** Living in urban/rural areas and/or living in which administrative region (province, state, district, etc.)<sup>[27]</sup>

To the extent possible, all efforts should be made to also disaggregate results by disability status and by ‘nationally relevant population groups’:

- **Disability status:** ‘Disability’ is an umbrella term covering long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder the full and effective participation of disabled persons in society on an equal basis with others<sup>[28]</sup>. If possible, NSOs are encouraged to add the [Short Set of Questions on Disability developed by the Washington Group](#) to the survey vehicle used to administer the 16.6.2 batteries to disaggregate results by disability status.
- **Nationally relevant population groups:** groups with a distinct ethnicity, language, religion, indigenous status, nationality or other characteristics.<sup>[29]</sup>
- **Age:** Empirical analysis shows that there is no statistically significant association between the age of respondents and satisfaction levels. However, if countries choose to also disaggregate results by age, it is recommended to follow UN standards for the production of age-disaggregated national population statistics, using the following age groups: (1) below 25 years old, (2) 25-34, (3) 35-44, (4) 45-54, (5) 55-64 and (6) 65 years old and above.

<sup>21</sup> The Afrobarometer is a pan-African, non-partisan research network that conducts public attitude surveys on democracy, governance, economic conditions, and related issues in more than 35 countries in Africa. [↓](#)

<sup>22</sup> While the fifth round (2011/13) of the Afrobarometer survey included several attributes-based question on healthcare and education services, subsequent rounds only include a few: “if there is a school or a health Clinic within easy walking distance”; and “how easy or difficult was it to obtain the medical care or services from teachers or school officials”. [↓](#)

<sup>23</sup> The European Social Survey (ESS) is a biennial cross-national survey of attitudes and behaviour established in 2001. In total, 37 countries have taken part in at least one round of the ESS since its inception. Surveys are conducted by leading academics and social research professionals. [↓](#)

<sup>24</sup> Eurofound’s European Quality of Life Survey (EQLS) documents living conditions and people’s social situation, and explores issues pertinent to the lives of European citizens. In operation since 2003, the EQLS 2016 – the fourth survey in the series – covered 33 countries – the 28 EU Member States and 5 candidate countries (Albania, the former Yugoslav Republic of Macedonia, Montenegro, Serbia and Turkey). provides detailed information on the quality of public services, including healthcare and education services. [↓](#)

<sup>25</sup> **Note:** For healthcare services, EQLS data would allow for the separate reporting of results (across all questions) on (1) primary care services (GP / doctor’s office / health centre) and (2) hospital or medical specialist services. Separate reporting on these two types of health care would be particularly

relevant for the ‘affordability’ attribute, given in European countries, primary care services typically cost little; more relevant would be to assess the affordability of hospital or medical specialist services, using question 67.e. [↑](#)

<sup>26</sup> However, question HC100 on ‘Affordability of formal education’ could be used in the European Union Statistics on Income and Living Conditions (EU-SILC) ad hoc module 2016. [↑](#)

<sup>27</sup> Based on the premise that decentralization efforts are aimed at extending local rights and responsibilities across the national territory, indicator 16.6.2 can help detect unequal access to services and disparities in the quality of services across localities. There is a risk for erroneous conclusions to be drawn from national aggregates unable to detect variations at sub-national level. [↑](#)

<sup>28</sup> UN General Assembly, Convention on the Rights of Persons with Disabilities: resolution / adopted by the General Assembly, 24 January 2007, A/RES/61/106, available at: <http://www.refworld.org/docid/45f973632.html> [↑](#)

<sup>29</sup> The population of a country is a mosaic of different population groups that can be identified according to racial, ethnic, language, indigenous or migration status, religious affiliation, or sexual orientation, amongst other characteristics. For the purpose of this indicator, particular focus is placed on minorities. *Minority groups* are groups that are numerically inferior to the rest of the population of a state, in a non-dominant position, whose members—being nationals of the state—possess ethnic, religious or linguistic characteristics differing from those of the rest of the population and show, even if only implicitly, a sense of solidarity directed towards preserving their culture, traditions, religion or language. While the nationality criterion included in the above definition has often been challenged, the requirement to be in a non-dominant position remains important (OHCHR, 2010). Collecting survey data disaggregated by population groups should be subject to the legality of compiling such data in a particular national context and to a careful assessment of the potential risks of collecting such data for the safety of respondents. [↑](#)

## 6. Comparability/deviation from international standards

Sources of discrepancies:

There is no internationally estimated data for this indicator.

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## Guidelines on survey methodology

- **An 'add-on' module:** The questions for 16.6.2 on healthcare, education and government services can be inserted into existing surveys, using these surveys' additional batteries on demographics for subsequent disaggregation of results. This modular 'add-on' technique also allows for the cross-tabulation of satisfaction levels with other socioeconomic variables found in the larger survey, such as the health conditions of the respondent. This enables a more comprehensive analysis of disparities in the provision of services, and helps to pinpoint specific factors that influence satisfaction levels.
- **Target population:** Residents of the country aged 18 or older.
- **Sampling:** As mentioned above, NSOs should strive to incorporate the 16.6.2 batteries of question in large-scale national surveys, also keeping in mind the large sample sizes needed for disaggregation of results by demographic sub-groups and by administrative region. "User surveys" such as this one, asking respondents to rate their satisfaction level "based on their last experience of public services in the past 12 months", may have implications for resources such as time, costs and other resources – since large sample sizes are needed to have reliable estimates for the subpopulation of service users. This is because the participation in the survey of some respondents will end when declaring that they have not used healthcare/education/government public services in the past 12 months. Data should be collected on the basis of a nationally representative probability sample of the population residing in private households within the country, irrespective of language, nationality or legal residence status. All private households and all persons aged 18 and over within the household are eligible for the question set. The sampling frame as well as methods of sample selection should ensure that results can be disaggregated at sub-national level, and that every individual and household in the target population is assigned a known probability of selection that is not zero (integrating 16.6.2 batteries in a household survey that targets household heads only should be avoided at all costs).

- **National ‘indigenization’ of the questionnaire:** Questions can, and should, be ‘indigenized’ to fit the national context – using appropriate terminology. For Q 3, 8 and 13, NSOs can remove inappropriate items from answer choices and incorporate additional ones, as pertinent in the local context. <sup>[30]</sup> *A copy of the ‘indigenized’ questionnaire, with a list of all changes made to the base questionnaire, and all translations in local languages, should be shared along with survey results at the time of reporting.*
- **Randomizing the order of services:** To minimize design effects that may arise from the order in which the battery of questions on education, healthcare or government services is presented to a respondent, the order of these batteries should be randomized, to the extent possible. In other words, some respondents should respond to the battery on healthcare services first, others should respond to the battery on education services first, and others still should respond to the battery on government services first – and likewise for the second and third batteries of questions. Regardless of the order, all respondents should respond to all three batteries. It is also recommended that the order of attributes-based questions in each service area be similarly randomized, if possible.
- **Clearly state the reference period:** Past 12 months
- **All answer categories should be read out loud *before* recording the respondent’s answer,** to be sure that the respondent’s preferred answer is identified based on all possible options. Showcards with the complete list of answer options could be shown to respondents (while they are being read aloud by the interviewer) for questions that have a long list of answer options.
- **Refer to enumerator instructions for additional guidance on terminology:** Enumerators should refer to the specific definitions and additional guidance provided in the questionnaire if respondents do not understand certain terms or certain questions. To ensure consistency in the way this methodology is applied across countries, enumerator should *not* try to explain terms in their own terms.
- **“Don’t know”, “refuse to answer” or “not applicable” should not be read out loud to respondents:** Providing a “don’t know” or “refuse to answer” option provides an easy way for respondents to avoid engaging with the subject of the question. As such, when respondents say they “don’t know”, enumerators should repeat the question and simply ask them to provide their best guess. The “don’t know” and “refuse to answer” options should be used only as a last resort. Enumerators should use separate coding for “not applicable” (NA – 97), “don’t know” (DK – 98) and “not applicable” (NA – 99), as indicated in the questionnaire.
- **Rigorous interviewer training** should be carried out to ensure that these guidelines for data collection are uniformly adopted and not potentially affected by other local practices of surveying.

## Questionnaire<sup>[31]</sup>

### Introduction

I am now going to ask you a few questions about the way public services are provided in [country name].

Your answers to this survey are important as they will help improve the provision of healthcare, education and government services across the country.

Your answers will be confidential. They will be put together with [xx – size of sample] other people we are talking to, to get an overall picture. It will be impossible to pick you out from what you say, so please feel free to tell us what you think. This interview will take about 15 minutes. There is no penalty for refusing to participate. Do you wish to proceed?

Let’s start with [insert name of service – healthcare, education or government – depending on randomized order for this respondent] services.

### Healthcare services

I would like to ask you a few questions about your experience with primary healthcare services over the past 12 months.

By this, we mean healthcare services provided a government/public health clinic [use specific name of public health facilities providing primary healthcare services in the country] or by a government-employed doctor/nurse, or healthcare services covered by a public health system [if applicable in the country].

Please do not include in your answers any experience you might have had with hospital services or specialist medical care services (for example, if you had a surgery). Dental care and teeth exams are also excluded.

1. Was there any time during the past 12 months when you (or a child in your household) really needed a medical examination or treatment?

A. Yes (There was at least one occasion in the past 12 months when I [or a child in my household] really needed medical examination or treatment) [go to 2]

B. No (There was no occasion in the past 12 months when I [or a child in my household] really needed medical examination or treatment) [End here. Go to next service area]

99. Refuse to answer

- **The aim of Q1-3 is to assess accessibility to primary healthcare services** – i.e. the most basic level of healthcare available to all citizens in a country, provided by a general practitioner, a family doctor or any national health facility providing primary healthcare services. If respondents used hospital services or specialist care services during the past 12 months, such as specialist services provided by a cardiologist, an endocrinologist or an allergist, these experiences should not be considered when responding to Q1-3.



- **Q1-3 focus on public healthcare services** – i.e. services that beneficiaries can receive from a government/public health clinic, by a government-employed doctor/nurse, or services that are covered by a public health system. It can also include healthcare services provided by private institutions, as long as such services are provided at reduced (or no) cost to beneficiaries, under a public health system.
- **Respondents who have not had a need for medical examination or treatment in the past 12 months but who are related to a child in their household who needed examination or treatment are invited to respond** to Q1-5 on the basis of their experience as the guardian of a child needing medical examination or treatment. However, respondents must have been *personally involved* in the care received (or not received) by the child in order to respond to Q1-5.
- According to the United Nations Convention on the Rights of the Child, a ‘**child**’ is “a human being below the age of 18 years unless under the law applicable to the child, majority is attained earlier”.
- ‘**Medical examination**’ includes regular preventive medical check-ups and diagnostics if those are perceived by the respondent as important.
- **Dental care** is excluded because in many countries, dental care is not covered by publicly funded healthcare systems.
- “... **when you really needed...**”: The word ‘really’ is used to ensure that only relevant health problems are taken into account i.e. situations perceived by the respondent as worrying or possibly causing additional health problems or further deteriorating health. Minor infections that do not require medical assistance should not be considered.

**2. Did you [or a child in your household] have a medical examination or treatment each time you [or a child in your household] really needed it?**

A. Yes (*I [or a child in my household] had a medical examination or treatment each time I [or a child in my household] needed it*) [go to 4]

B. No (*there was at least one occasion when I [or a child in my household] did not have a medical examination or treatment when I [or a child in my household] needed it*) [go to 3]

99. Refuse to answer

**3. What was the main reason for not having the medical examination or treatment?**

1. Could not afford to (too expensive)
2. Long waiting list (to get an appointment, or when turning up to a health facility without an appointment)
3. Too far to travel or no means of transportation to get there
4. Didn't know any good medical doctor or health professional
5. Could not take time because of work, care for children or for other reasons
6. Wanted to wait and see if problem got better on its own
7. Fear of medical doctors, hospitals, examination or treatment
8. Healthcare facilities are not clean
9. Healthcare facilities are not adequately equipped or lack medicine
10. Other reasons: \_\_\_\_\_

- **If it happened to both the respondent and a child in his/her household (not to have a medical examination or treatment when they needed it)**, the respondent should answer based on his/her personal experience and provide the reason why s/he did not receive medication examination/treatment.
- “**Could not afford to (too expensive)**” should not be interpreted as “more expensive than before”; this answer should be selected when the respondent could not pay the price of the treatment/examination him/herself.
- “**Long waiting list**”: This answer is to be used for (1) respondents experiencing delays in getting an appointment (to see a health professional) soon enough to meet their need of care; (2) for respondents who were discouraged from seeking care because of perceptions of long waiting times; or (3) for respondents who encountered a long waiting time to see a health professional the day care was needed, when turning up at a health facility without an appointment.
- “**Wanted to wait and see if problem got better on its own**” can include situations where respondents preferred to heal naturally instead of using drugs or surgery.
- “**Didn't know any good medical doctor or health professional**” is to be selected if the respondent does not know where to find competent doctors or other health professionals.
- “**Fear of medical doctors, hospitals, examination or treatment**” relates to the emotional anxiety sometimes provoked by medical personnel or medical facilities, irrespective of the professional competence of health professionals.

**4. I now want to ask you some questions about the last time you [or a child in your household] had a medical examination or treatment, in the past 12 months.**

Thinking about this last experience, would you say that:

		Strongly agree	Agree	Disagree	Strongly disagree	NA	DK	RA
4.1	It was easy to get to the place where I received medical treatment.	3	2	1	0	97	98	99

4.2	Expenses for healthcare services were affordable to you/your household.	3	2	1	0	97	98	99
4.3	The healthcare facilities were clean and in good condition.	3	2	1	0	97	98	99
4.4	All people are treated equally in receiving healthcare services in your area.	3	2	1	0	97	98	99
4.5	The doctor or other healthcare staff you saw spent enough time with you <i>[or a child in your household]</i> during the consultation.	3	2	1	0	97	98	99

- **Q4 to be responded only by respondents who have received a healthcare service in the past 12 months:** Question 4 must be based on first-hand experience of a healthcare service by the respondent. If the respondent said s/he did *not* have medical examination or treatment each time s/he really needed it, during the past 12 months, select N/A for Q4.1-4.5.
- The aim of Q4 is to ask respondents to provide their **personal evaluation of specific attributes** of the last healthcare service they received in the past 12 months.
- **“It was easy to get to the place where I received medical treatment”:** This means that the doctor’s office, clinic or health facility could be reached by public or private transportation without difficulties. It also means that adequate means of transportation to get to the doctor’s office, clinic or health centre were available to the respondent (e.g. a respondent in a wheelchair who took a local bus that could not accommodate wheelchairs will respond ‘no’, i.e. s/he had difficulties.) A range of other issues can also be considered by respondents, such as delay in getting appointment, or long waiting time to see doctor on day of appointment.
- **Distinguishing 4.4. from 4.5:** While 4.4 focuses on respondents’ perception about the equal treatment of *everyone in society* by medical staff, 4.5 is specifically concerned about the respondent’s *own* experience with the doctor/health professional.

**5. Overall, how satisfied or dissatisfied were you with the quality of primary healthcare services you *[or a child in your household]* received on that last consultation?** (i.e. the last time you *[or a child in your household]* had a medical examination or treatment in the past 12 months)

Very satisfied	Satisfied	Dissatisfied	Very dissatisfied	NA	DK	RA	
3	2	1	0	97	98	99	

- **The aim of Q5 is to ask respondents for their personal evaluation** of their overall experience with the last healthcare service they received in the past 12 months.
- **Q5 only for respondents who have received a healthcare service in the past 12 months:** Question 5 must be based on the first-hand experience of a healthcare service by the respondent. If the only time (or each time) the respondent really needed medical examination or treatment during the past 12 months, s/he did *not* have it, select N/A for Q5.

#### Education services

The next few questions focus on your experience with the primary and secondary public school system. By this, we mean public schools that are funded by the state.

#### 6. Are there children in your household whose age falls between 4 and 16 years old?

A. Yes (There are children in my household whose age falls between 4 and 16 years old)

B. No (There are NO children in my household whose age falls between 4 and 16 years old)

[End here. Go to next service area]

99. Refuse to answer

- **If necessary, replace the above age range** (4-16 years old) with the appropriate age range spanning primary and secondary education in the country.

#### 7. Does this child (do all of these children) attend a public school regularly?

A. Yes [go to 9] (All children in in my household whose age falls between 4 and 16 years old attend a public school regularly)

B. No [go to 8] (There is at least one child in my household whose age falls between 4 and 16 years old who does NOT attend a public school regularly)

98. Don't know

99. Refuse to answer

- **The aim of Q6-8 is to assess accessibility to public education services for the child/children in the respondent's household.**
- **Emphasize the focus on public schools:** These questions are strictly concerned with education services provided by public (state-funded) schools. Those sending their children to a private school, or home schooling them, should respond 'no' to Q7 and select A or B under Q8, and should not be asked Q9-10.
- **"...attend a public school regularly."** means that children go to school every day except on days when they are sick, or when the school is closed, etc.

**8. What is the main reason for this child/some children in your household not to attend a public school regularly?**

1. Child/children in my household attend a private school [End here. Go to next service area]
2. Child/children in my household are home-schooled [End here. Go to next service area]
3. Cannot afford to (school-related expenses, including administrative fees, books, uniforms and transportation, are too expensive)
4. The nearest school is too far away and/or transportation is not available
5. School facilities are in poor conditions
6. The school and its compound are not safe
7. Teachers and other school staff do not treat children with respect
8. Teachers are ineffective/not adequately trained
9. Teachers are often absent
10. Child/children need to stay home to help with housework/farm work
11. No culturally or religiously appropriate educational programs available
12. School not equipped for children with special learning needs
13. Other reasons:

- **Private schools** are schools founded and maintained by a private group rather than by the state, and usually charge tuition fees.
- **Home schooling**, also known as ‘home education’, is the education of children inside the home. It is usually conducted by a parent, tutor or online teacher.
- **“Cannot afford to (school-related expenses, including administrative fees, books, uniforms and transportation, are too expensive)”**: This answer category may not apply in contexts where public schools are virtually free, except for a few school supplies and/or optional field trips.
- **“School facilities are in poor conditions”**: This refers to schools where there is no/limited access to safe drinking water and to separate toilet facilities for girls and boys; where school buildings are affected by hazards such as a leaky roof, mould, lead, asbestos or indoor air pollution; and/or where the school compound and classrooms are not kept clean and/or free of harmful waste material.
- **“School facilities are not safe”**: This refers to schools where children are exposed to physical and psychological risks in and around the school. This includes physical violence, such as gang violence or corporal punishment by teachers, bullying among students and sexual harassment. It also includes schools attacked during civil conflicts, and schools where children are at risk of kidnapping and forced recruitment as child soldiers, labourers or sex slaves.
- **“Teachers and other school staff do not treat children with respect”**: This includes situations where there is perceived discrimination or prejudice against children based on their sex, national origin, racial or ethnic background, religion, indigenous status, etc.
- **School not equipped for children with special learning needs**: Children with ‘special learning needs’ have learning problems or disabilities that make it harder for them to learn than most children of the same age. Such learning needs can be physical (e.g. muscular dystrophy, multiple sclerosis, chronic asthma, epilepsy, etc.), developmental (e.g. Down syndrome, autism, dyslexia, processing disorders, etc.) or behavioural/emotional (e.g. attention deficit disorder, bi-polar, oppositional defiance disorder, etc.)

**9. Please tell me more about the primary and/or secondary public schools attended by this child/children in your household:**

- **If necessary, replace ‘primary’ and ‘secondary’ schools with terms more commonly used in the national context:** In some contexts, primary school may be referred to as ‘elementary school’ and secondary school may be referred to as ‘high school’, ‘middle school’, ‘junior high’ and/or ‘senior high’.
- **Ask respondents to respond separately for primary and secondary schools if children in their household attend school at different levels,** i.e. if some respondents have two or more children in their household attending different school levels, ask the below set of questions twice: first in relation to primary schools, and second in relation to secondary schools.

**Are you reporting on:**

1. Primary school in your area \_\_\_\_
2. Secondary school in your area \_\_\_\_

[illegible]

		Strongly agree	Agree	Disagree	Strongly disagree	NA	DK	RA
9.1	The school can be reached by public or private transportation, or by walk, in less than 30 minutes and without difficulties.	3	2	1	0	97	98	99
9.2	School-related expenses (including administrative fees, books, uniforms and transportation) are affordable to you/your household.	3	2	1	0	97	98	99
9.3	School facilities are in good condition.	3	2	1	0	97	98	99
9.4	All children are treated equally in the school attended by the child/children in your household.	3	2	1	0	97	98	99
9.5	The quality of teaching is good.	3	2	1	0	97	98	99

- **“The school can be reached [...] without difficulties.”:** This means that adequate means of (public or private) transportation are available to children to get to the school, if it is not possible to walk to school, and that these means of transportation are safe (e.g. A respondent whose child is in a wheelchair and does not have access to transportation that has service to accommodate the child’s wheelchair will respond ‘no’, i.e. s/he has difficulties.)
- **All children are treated equally in the school attended by the child/children in your household:** Respondents are here asked whether they perceive some form of discrimination or prejudice against some children in the school in their area, based on their national origin, racial or ethnic background, religion, indigenous status, etc.
- **The quality of teaching is good.** Respondents are here asked to focus on the outcomes of education services, i.e. whether children are actually learning at the level expected for their grade.
- **See other relevant comments on terminology provided for Q8 above**

**10. Overall, how satisfied or dissatisfied are you with the quality of education services provided by the primary and/or secondary public schools attended by this child/children in your household?**

- **Ask respondents to respond separately for primary and secondary schools if children in their household attend school at different levels,** i.e. if some respondents have two or more children in their household attending different school levels, ask the below set of questions twice: first in relation to primary schools, and second in relation to secondary schools.

**Are you reporting on:**

1. Primary school in your area \_\_\_\_
2. Secondary school in your area \_\_\_\_

Very satisfied	Satisfied	Dissatisfied	Very dissatisfied	NA	DK	RA	
3	2	1	0	97	98	99	

- **The aim of Q10 is to ask respondents to give their personal evaluation** of their overall experience with primary and secondary public education services in their area.

**Government services**

**I am now going to ask you a few questions about government services in [country name].**

- **The aim of Q11-14 is to assess accessibility to government services.**
- The focus here is on two frequently used government services: 1) Services to obtain government-issued identification documents (i.e. four such documents are mentioned in Q11 below: national identity cards, passports, drivers’ licenses and voters’ cards) and 2) services related to the civil registration of life events (i.e. four such documents are mentioned in Q11 below: certificates of birth, death, marriage and divorce).

**11. In the past 12 months, did you need to obtain a piece of government-issued identification, such as [NSOs should provide a full list of relevant documents, based on national context, using a showcard if the list is long. This list may include: a national identity card, a passport, a driver's license, a voter's card, or a certificate of birth, death, marriage or divorce]?**

A. Yes (I needed to obtain at least one of [full list of relevant documents, based on national context] in the past 12 months) [Go to 12]

B. No (I did NOT need to obtain any of [full list of relevant documents, based on national context] e in the past 12 months) [end here]

99. Refuse to answer

- **“Did you need to obtain...”** means that the respondent *wanted* to obtain such government-issued identification documents, irrespective of the reason why such documents were needed. This includes situations where respondents had to renew an expired identification.
- **NSOs should tailor the list of government-issued identification documents in this question to their national context** and include only those in use in the country, and for which citizens actually need to file an application. For instance, national identity cards may not exist, or voters' cards may simply be mailed to a person before voting, etc. Depending on the national context, other relevant ID documents that could be added including permanent resident cards and citizenship cards. Showcards with the complete list of relevant documents could be shown to respondents (while they are being read aloud by the interviewer) if the list is long.

**12. Did you try to obtain all document(s) you needed from the civil registration services or other relevant agencies?**

A. Yes (I did try to obtain all document(s) I needed from the civil registration services or other relevant agencies) [Go to 14]

B. No (I did NOT try to obtain at least one document I needed from the civil registration services or other relevant agencies) [Go to 13]

99. Refuse to answer

**If no, please specify the document(s) you did not try to obtain:** \_\_\_\_\_

- **Q12 aims to capture attempts to obtain identification documents, irrespective of whether these attempts were successful or not.**
- For the open-ended question 12 on the documents the respondent tried to obtain, a pre-coded list of 10 to 20 types of documents will be developed, plus an "other" options for a write-in.
- **NSOs should replace ‘civil registration services or other relevant agencies’ with the name of the particular agency(ies) responsible for issuing such identification documents in the country.**

**13. What is the main reason you did not try to obtain such document(s) from the civil registration services or other relevant agencies?**

1. Cannot afford to (administrative fees are too expensive)
2. Too difficult to access the ‘point-of-service’ (office, phone number, website)
3. The staff do not treat people with respect
4. The process for applying and obtaining such documents is too complicated
5. It takes too long to get what you need
6. Other reasons: \_\_\_\_\_

[End here if the respondent did not try to obtain a single document. Continue with Q14-16 if the respondent tried at least once to obtain a document, in the past 12 months.]

**14. I now want to ask you some questions about the last time you tried to obtain an ID or a certificate of birth, death, marriage or divorce in the past 12 months.**

1. Please tell me what was the last document you tried to obtain: \_\_\_\_\_
2. Did you apply for this document online?

A. Yes [I applied online]

B. No [I did NOT apply online]

99. Refuse to answer

- For the open-ended question 14 on which document the respondent last tried to obtain, a pre-coded list of 10 to 20 types of documents will be developed, plus an "other" options for a write-in.
- **“Did you apply for this document online?”:** This additional context will help refine the analysis of results on Q15, helping to distinguish satisfaction levels for services provided online from satisfaction levels for services provided offline.
- **NSOs can skip this question (14b)** if obtaining such documents cannot be done online in their country.

**15. Thinking about this last time you tried to obtain [name of the document identified by the respondent in 14a], would you say that:**

		Strongly agree	Agree	Disagree	Strongly disagree	NA	DK	RA
15.1	The office, website or [toll free] telephone number was easily accessible.	3	2	1	0	97	98	99
15.2	The fees you needed to pay for the ID or the certificate were affordable to you/your household.	3	2	1	0	97	98	99
15.3	The process for applying and obtaining the ID or the certificate was simple and easy to understand.	3	2	1	0	97	98	99
15.4	All people are treated equally in receiving government services in your area.	3	2	1	0	97	98	99
15.5	The amount of time it took to obtain the ID or the certificate was reasonable.	3	2	1	0	97	98	99

- The aim of Q15 is to ask respondents to provide their **personal evaluation of specific attributes** of the last government service they received in the past 12 months.

**16. Overall, how satisfied or dissatisfied were you with the quality of government services you received on that occasion?**  
(i.e. the last time you applied for an ID or a certificate of birth, death, marriage or divorce in the past 12 months)

Very satisfied	Satisfied	Dissatisfied	Very dissatisfied	NA	DK	RA	
3	2	1	0	97	98	99	

- **The aim of Q16 is to ask respondents to give their personal evaluation** of their overall experience with the last government service they received in the past 12 months.

<sup>30</sup> For instance, some answer items may not apply to middle-income or high-income country settings, such as “Healthcare facilities are not adequately equipped or lack medicine” under Q3, or “Children need to stay home to help with housework/farm work” under Q8. [↑](#)

<sup>31</sup> The survey module for this indicator is undergoing further development and testing by UNDP, in line with this metadata. A slightly refined module will be finalised and ready for use in mid 2020. [↑](#)